Organization and Financing of ID-DD and MH Services: National Perspective

Presentation to the Iowa Legislative Interim Committee

Technical Assistance Collaborative, Inc.
Human Services Research Institute, Inc

October 24, 2011

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ID-DD Services

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Medicaid Waivers Are the Dominant Funding Source

- Waiver programs for people with ID/ DD account for about 75% of all Medicaid waiver spending
- In 2008, there were about 525,000 waiver recipients with DD – a 740% increase from 1992
- Total cost in '08 was 22.3 billion – about $42,500 per recipient
- Five times as many people receive waiver services than are served in ICFs/MR

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Distribution of Medicaid Funding

		Number Served	Total Dollars	Average Per Person
HCBS Waiver (s)				
Home and Community Based Intellectual Disabilities Waiver		11,083	$303,084,159.12	$27,346.76
Other waivers with individuals with IDD		2,900	$20,587,120.00	$7,099.01
	Sub-total	13,983	$323,671,279.12	$23,147.48
ICF/MR				
Public ICF/MR		528	$114,668,400.00	$217,175.00
Private ICF/MR		1,528	$190,705,372.00	$124,807.18
	Sub-total	2,056	$305,373,772.00	$148,528.10
Combined Total		**16,039**	**$629,045,051.12**	**$39,219.71**

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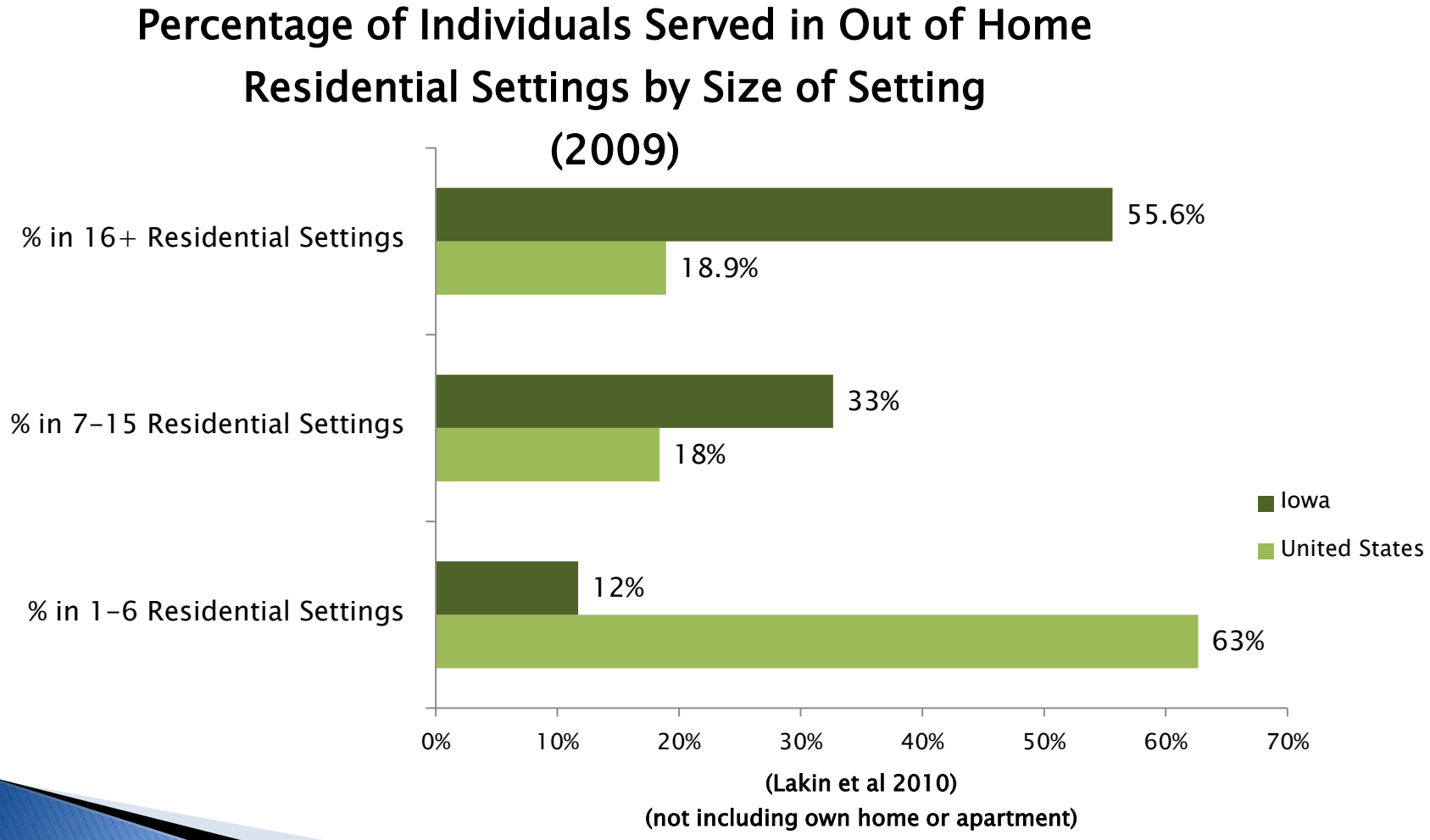
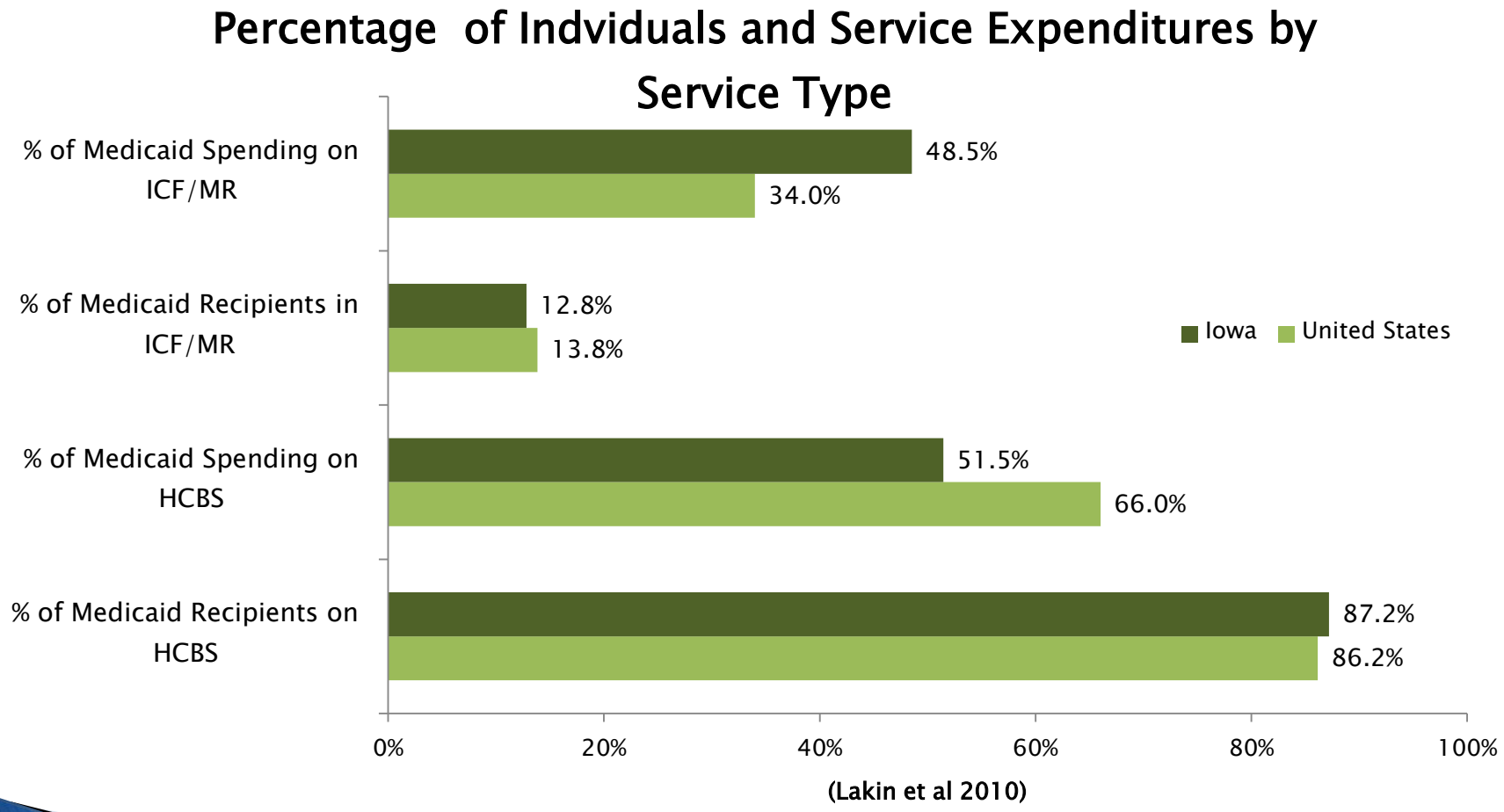
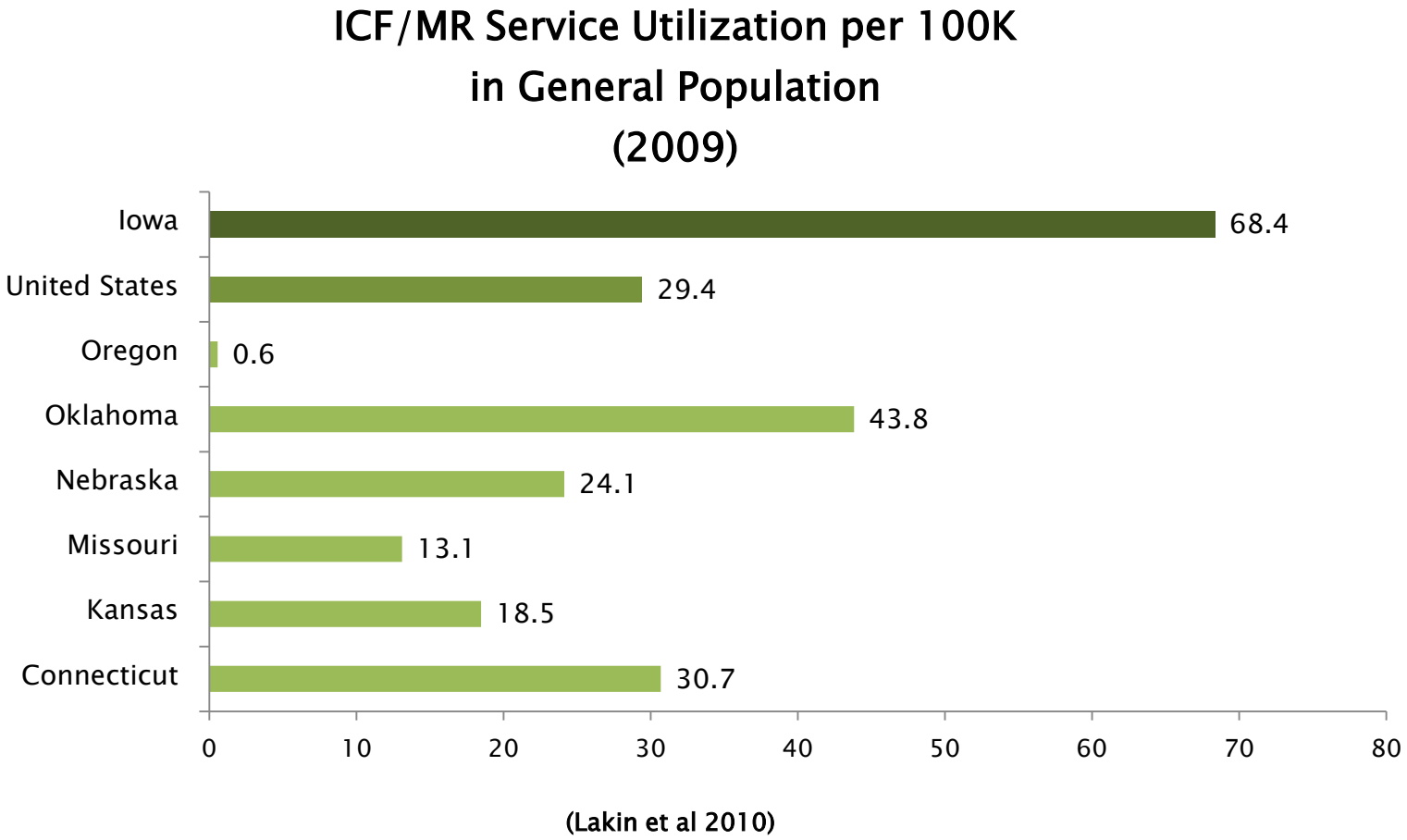
Size of Settings – IA vs. US



How IA Allocates Medicaid $$$

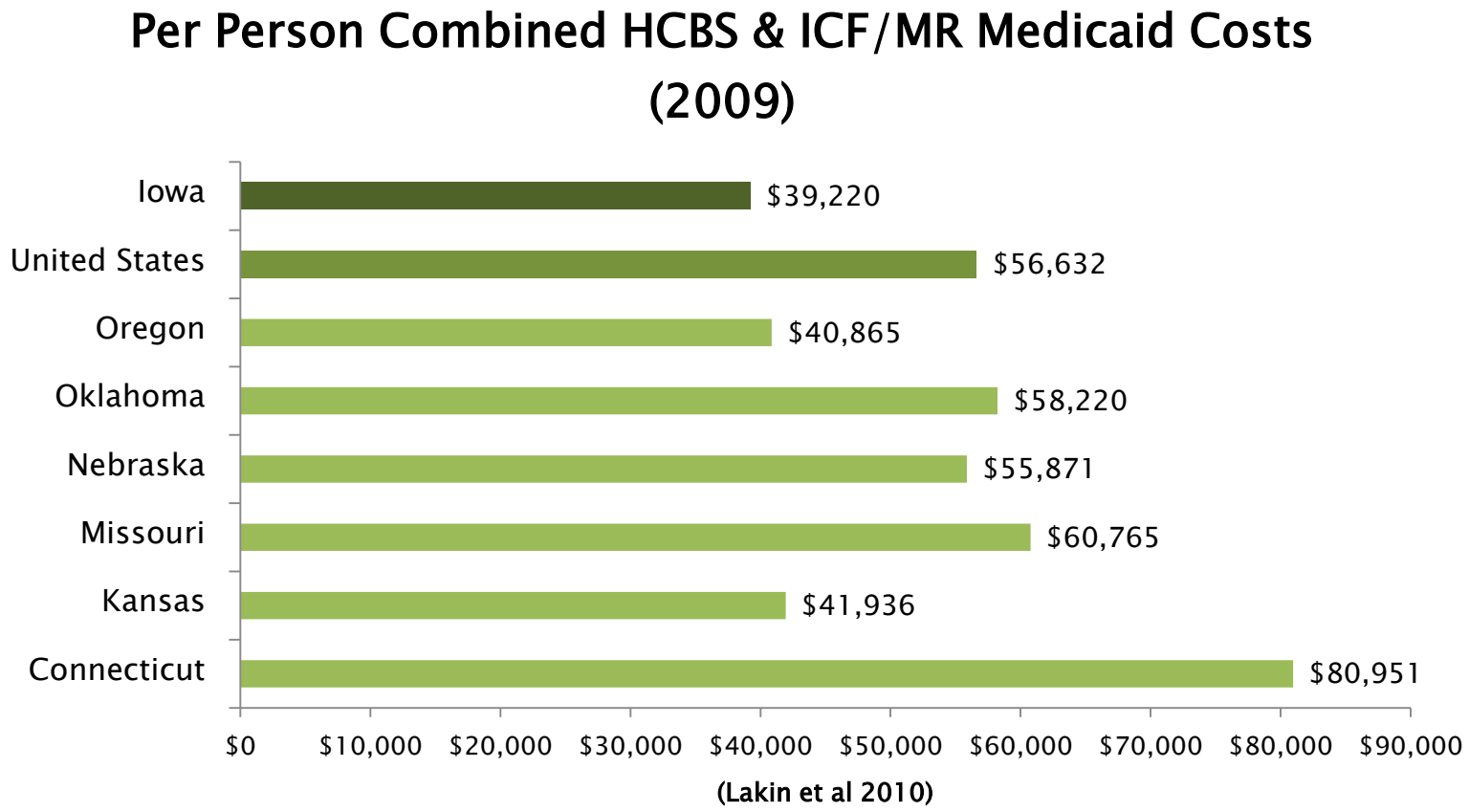


Reliance on ICF/MR – IA vs. US



(Lakin et al 2010)

Per Person Cost – IA vs. U.S.



Adult MH Services

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SMHA Organization in 2010

SMHA Located in State Department	Levels between Commissioner & Governor	SMHA Director Reports to MH Board/Council
Independent = 11 Human Services=24 Health Department=10 Health & Human Services=5 No Response=1	0 (Direct Governor)=5 1 (One Level)=26 2 (Two Levels)=17 3 (Three + Levels)=1 No Response=2	Yes = 14 No = 35 No Response = 2
Iowa = Human Services	*Iowa = 2*	*Iowa = No*

SMHA Relationship with Other State Agencies

Substance Abuse	Intellectual Disabilities	Medicaid
Part of SMHA = 31 Same Umbrella = 14 Other Agency = 5 No Response = 1	Part of SMHA = 12 Same Umbrella = 30 Other Agency = 8 No Response = 1	Part of SMHA = 2 Same Umbrella = 29 Other Agency = 19 No Response = 1
Iowa = Other Agency	Iowa = Part of SMHA	Iowa = Same Umbrella

Use of Fee-for-Service and/or Managed Care for Mental Health Medicaid Services: 2010

Medicaid Mental Health Services are funded through Fee-for-Services Only	Medicaid Mental Health Services are funded through Managed Care Only	Medicaid Mental Health Services funded through a combination of Fee-for-Services and Managed Care
Yes = 19; No = 17	Yes = 4; No = 23	Yes = 25; No = 12

How Do SMHAs Organize and Fund Community Mental Health Services: 2010

SMHA Relationship with Community Mental Health Providers			The primary mechanism used by the SMHA to administer its funds in support of community-based health services.	
SMHA directly provides funds, but does not operate local community-based agencies.	SMHA funds county (single or multi-county) or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services:		SMHA directly operates community-based programs.	
	County/City System is Statewide	County/City System in Parts of State		
Yes = 38	Yes = 16	Yes = 3	Yes = 14	29 = SMHA directly funds, but doesn't operate community agencies 7 = SMHA directly operates community agencies 14 = SMHA Funds County or City MH
Iowa = Yes	Iowa = Yes			Iowa: SMHA funds county or city MH authorities: statewide coverage

NASMHPD Research Institute, 2010
State Mental Health Agencies
Profiling System

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Per Capita Funding

2007	SMHA Expenditure	Rank	Per Capita	Per Capita Rank
Iowa	$310,670,000	28th	$104.20	24th
National Average	$679,900,270	--	$119.00	--

2009	SMHA Expenditure	Rank	Per Capita	Per Capita Rank
Iowa	$409,656,006	26th	$136.27	20th
National Average	$736,895,886	--	$129.00	--

NASMHPD Research Institute, State Mental Health Agencies Profiling System

SMHA MH-controlled per capita expenditures for State Hospitals, Community Services, Research and Administration, 2005

2009	State Hospital %	State Hospital Rank	Comm-based Programs %	Comm-based Programs Rank	Prevention, Research, Training, Admin %	Prevention, Research, Training , Admin Rank
Iowa	11%	41st	87%	21nd	2%	29th
Average	27%	--	70%	--	1%	--

% = percent of each state's total budget for mental health.
Rank = The per capita spend compared with other states/territories.
Iowa did not report data for 2009.
NASMHPD Research Institute, 2009 State Mental Health Agencies Profiling System

State Hospital Residents per capita 2008

Funding Characteristics for State Mental Health Agencies, 2009

	Residents per 100,00 pop.
Iowa	6.8
Average	18

Children's Disability Services

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Realignment of Funding Streams and Structures in Children's Systems of Care

"A multitude of funding streams at federal, state, and local levels can be drawn upon to support systems of care. However, the maze of funding streams that finance children's mental health services must be better aligned, better coordinated, and, often, redirected, to provide individualized, flexible, home and community-based services and supports. Based on a careful analysis, a strategic financing plan "realigns" resources to develop a more coherent, effective, and efficient approach to financing the infrastructure and services that comprise systems of care. Such realignment involves using resources from multiple funding streams, maximizing the use of entitlement programs (such as Medicaid), redirecting and redeploying resources, and improving the management and coordination of resources."

… University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #235-02**)

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Snapshot of Children's System of Care Funding Approaches in Other States

- *Arizona and Maricopa County: A statewide behavioral health carve out operated* under an 1115 waiver utilizing locally-based, capitated Regional Behavioral Health Authorities (i.e., behavioral health managed care organizations — BHOs); the BHO in Maricopa County (Phoenix) at the time of the site visit was Value Options

- *Hawaii: A statewide behavioral health system operated through the schools and* managed care organizations for children needing short-term services and through the state Child and Adolescent Mental Health Division for children with serious emotional challenges and their families

- *New Jersey: A behavioral health carve out utilizing a statewide Administrative* Services Organization and locally-based Care Management Organizations and Family Support Organizations

- *Vermont: A statewide mental health system managed by the Department of Mental* Health utilizing legislatively-mandated state and local interagency teams and designated provider agencies

Stroul, B.A., Pires, S.A., Armstrong, M. I., McCarthy, J., Pizzigati, K., & Wood, G.M., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02). Tampa, FL:* University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #235-02)**

Financing Strategies Include…

- Utilize Diverse Funding Streams
- **Maximize Federal Entitlement Funding**
- Redirect Spending from "Deep-End" Placements to Home and Community-Based Services
- **Support a Locus of Accountability for Service, Cost, and Care Management for Children With Intensive Needs**
- Increase the Flexibility of State and/or Local Funding Streams and Budget Structures
- **Coordinate Cross-System Funding**
- Incorporate Mechanisms to Finance Services for Uninsured and Underinsured Children and their Families

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Utilizing Funding from Multiple Agencies to Finance Services and Supports

The sites studied use resources from multiple child-serving systems to finance services and supports. Resources from mental health, Medicaid, child welfare, juvenile justice, and education are used by all of the sites. Resources from the substance abuse, developmental disabilities, and health systems are included in the financing mix less frequently, but are included in some of the sites. **Table 1** shows the extensive use of cross-system funding to contribute to financing a broad array of services and supports.

Table 1.
Use of Multiple System Resources

Source	Arizona	Hawaii	Vermont	Central Nebraska	Choices	Wraparound Milwaukee	New Jersey
Mental Health	X	X	X	X	X	X	X
Medicaid	X	X	X	X	X	X	X
Child Welfare	X	X	X	X	X	X	X
Juvenile Justice	X	X	X	X	X	X	X
Education	X	X	X	X	X	X	
Substance Abuse	X			X			X
Developmental Disability	X	X			X	X	
Health			X				

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Use Multiple Medicaid Options and Strategies

The sites studied have maximized Medicaid financing of behavioral health services for children by taking advantage of the multiple options available to states under the Medicaid program, including the clinic and rehabilitation options, targeted case management, EPSDT, and several different types of waivers. **Table 2** demonstrates the extensive use of multiple options.

Table 2

Use of Multiple Medicaid Options

	Arizona	Hawaii	Vermont	Nebraska	New Jersey
Clinic Option	X	X	X	X	X
Rehab Option	X	X	X	X	X
Targeted Case Management		X	X	X	X
Psych Under 21	X	X	X	X	X
EPSDT	X	X	X	X	X
Katie Becket (TEFRA)			X	X	
H & CB Waiver (1915c)	DD*	DD*	X**	DD*	DD*
1915b Waiver			X		
1115 Waiver	X	X	X***		
Family of One	X				

*DD = Developmental Disabilities **DD and SED waivers ***1115 (a) Global Commitment Waiver

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State-Specific Example…

HI Hawaii

Utilizing Resources from Multiple Systems

Resources from multiple agencies/sources include:

- **Mental health general revenue** — Funds staff, services and supports not covered by Medicaid, payments to providers above the Medicaid rate (which "makes it or breaks it" for providers)
- **Medicaid** — through a carve-out operated by the Child and Adolescent Mental Health Division (CAMHD)'s children's mental health system
- **Block Grant** — Funds screening and assessment of children in family court, screening and assessment of children in the child welfare system, statewide family organization, young adult support organization, early intervention and prevention, services for homeless children, etc.
- **Title IV-E** — Funds training, administrative costs, some costs for treatment of children in foster care system
- **SAMHSA Grants** — Fund system of care development, alternatives to seclusion and restraint, data infrastructure development. A grant from the Comprehensive Community Mental Health Services for Children and their Families Program funded system of care development in two areas on Oahu; a new grant from SAMHSA is financing system of care development for youth in transition to adulthood in one area of the state.
- **Education System** — Funds the cost of education in residential treatment programs
- **Office of Youth Services** — Funds an array of community-based services for children at risk for incarceration, including some community gang interventions, substance abuse services, sex offender services, sex abuse services, youth development, and some cost sharing on an individual case basis
- **Developmental Disabilities** — Provides cost sharing as needed on an individual case basis

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State-Specific Example…

VT Vermont

Exploring a Medicaid Waiver to Pool Resources for Children with Multiple Needs

The state negotiated a first of its kind 1115 (a) Medicaid waiver with the federal government in 2005. Called the Global Commitment Waiver, it is designed to reform the state's Medicaid program by helping both the state and federal governments manage Medicaid expenditures at a sustainable level over the five year pilot period. Under this waiver, the state accepts a cap on its Medicaid funding in exchange for greater flexibility in how it spends its Medicaid funds, and with the increased flexibility, the state hopes to provide more individualized services and to produce better outcomes. Related to this, ***Vermont´s*** child-serving partner agencies identified difficulties in funding services for children with multiple, severe needs as a high priority. Under the authority of the Global Commitment Medicaid waiver, the state is working to establish a mental health funding resource that would create a pool of resources funded by several agencies for services and supports for children with multiple and serious needs. Contributing agencies are likely to include: mental health, child welfare, education, health and substance abuse, developmental services, and juvenile justice.

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State-Specific Example…

AZ Arizona and Wraparound Milwaukee Wraparound Milwaukee

Using Family of One

"Family of One" allows States to waive parental income limits for a child who is expected to utilize an institutional level of care for 30 days or more.

- ***Arizona*** uses the "Family of One" strategy for inpatient and residential treatment services, in addition to other Medicaid options.
- ***Wisconsin*** uses this strategy for inpatient services only.

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State-Specific Example…

AZ Arizona

Using 1115 Waiver to Develop Home and Community-Based Services

The entire thrust of the 1115 Medicaid waiver is to develop home and community-based alternatives to out-of-home services. The ***Arizona*** behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of covered services and supports by adding new service types to the Medicaid benefit and expanding service definitions of already covered services. In addition, rates were restructured to better correspond to system goals of encouraging the provision of home and community-based services and reduced reliance on residential treatment. Rates for residential treatment, for example, decline as lengths of stay increase. The state reported that in 2003, 39% of the child behavioral health budget went to 3.6% of enrolled children served in residential treatment centers (RTC) and inpatient hospitals. In 2005, this had been reduced to 29%–16.25% on inpatient hospitalization and 13.4% on other out-of-home (residential Levels I, II, III, including therapeutic foster care). Currently, 2.6% of the 33,000 youth served statewide (about 850 youth) are served in out-of-home treatment settings, but 40% of those placements are in family-based therapeutic foster care (TFC), rather than congregate settings. In 2003, the system had nine TFC placements statewide, compared to about 400 today. Value Options (VO) in Maricopa reported that it spent $25–30 million of its budget (about 25%) on out-of-home services and $70–90 million (about 75%) on home and community-based services. At the same time, child welfare in Maricopa reported that it is spending less on RTC because of successful appeals to get VO to pay for the service.

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State-Specific Example…

NE Central Nebraska

Developing a System of Care for Children in State Custody

The Cooperative Agreement between the ***Nebraska*** Department of Health and Human Services (DHHS) and Region 3 Behavioral Health Services (BHS) to create an individualized system of care for children in state custody who have extensive behavioral health needs identifies reinvestment of cost savings to allow for more preventative, front-end, community-based services as one of its core principles. The agreement stipulates that if Region 3 BHS experiences costs less than the agreement amount, an expected outcome of the program, the cost savings may be used to: develop a risk pool (no more than 10%), serve additional youth in the target population or expand services to youth at risk of becoming part of the target population, and provide technical assistance to other Regions/ Service Areas to implement similar programming statewide.

In its 2005 Annual Report, Region 3 BHS demonstrates that the Integrated Care Coordination Unit has reduced out-of-home placements and increased the percentage of children who live in the community:

- At enrollment, 35.8% of the children (n= 341) were living in group or residential care; at disenrollment 5.4% of the children were in group or residential care
- At enrollment 2.3% were living in psychiatric hospitals; at disenrollment no children were hospitalized
- At enrollment 7% were living in juvenile detention or correctional facilities; at disenrollment no children were in these facilities
- At enrollment 41.4% were living in the community (at home – 4.4%, with a relative — 1.5%, or in foster care — 35.5%); at disenrollment, 87.1% lived in the community (at home — 53.5%, with a relative — 7.6%, in foster care — 14.5%, independent living — 11.5%).

Other outcome measures show that CAFAS scores dropped significantly (i.e., improved) for children enrolled in the Professional Partners Program, Integrated Care Coordination Unit, or Early Intensive Care Coordination, and their living situations improved.

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State-Specific Example…

AZ Arizona

Increasing Funds Spent on Home and Community-Based Services

Through the managed care system and as a result of the JK lawsuit, there has been an increase in dollars spent on home and community-based services. The behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of Medicaid-covered services, both by adding new service types and expanding service definitions of already covered services. Rates were restructured to encourage provision of home and community-based services. A new type of Medicaid provider was created — community service agencies — specifically to broaden the availability of home and community based services. In addition, ***Arizona*** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) includes non-Medicaid dollars, including state general revenue and block grant funds, in the capitation that Regional Behavioral Health Authorities (RBHAs) receive, which can be used for expanding the availability of home and community-based services. Any "savings" generated through managed care are re-invested, and there is a legislative prohibition against using savings generated by children's programs for adult services. Value Options (VO) in Maricopa County has used savings to expand the availability of therapeutic foster care.

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Examples of Accountability for Children's Systems of Care Management

While systems of care activities—oversight, initiatives, development—occur routinely and at multiple levels (family-level, community-level, regional-level, state-level), *"many (jurisdictions) finance some type of entity as a locus of accountability and management for children with serious and complex challenges, who are involve in or at risk for involvement in multiple systems. These may be a government entity or a private non-profit entity."*

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State-Specific Example…

HI Hawaii

Using a State Government Agency

Hawaii's children's mental health system is administered by the state government, specifically the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health (DOH). Over the past five years, CAMHD's system of care shifted from a comprehensive mental health service system for all children and youth to a system focused on providing more intensive mental health services to the population of youth with more serious and complex behavioral health disorders and their families. Through a memorandum of understanding (MOU) with the state Medicaid agency, CAMHD operates a carve-out under the state Medicaid program that serves youth with serious emotional and behavioral disorders (the Support for the Emotional and Behavioral Development of Youth or SEBD Program). CAMHD receives a case rate from Medicaid for each child in service and provides a comprehensive array of services and supports. Operation as the prepaid health plan for Medicaid eligible youth began in 2002. The functions under the purview of the state office include governance of the system, performance management, business and operational management, research and evaluation, and training and practice development/improvement. Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers), located throughout the state, which are responsible for mental health service delivery to children and adolescents and their families. CAMHD also contracts with a range of private organizations to provide a full array of mental health services. Public employees within the Family Guidance Centers provide care coordination services, assessment and outpatient services, and arrange for additional services with contracted provider agencies.

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State-Specific Example…

NJ New Jersey

Using Nonprofit Care Management Organizations

New Jersey's system of care initiative created Care Management Organizations (CMOs), which are nonprofit entities at the local level (one per region) that provide individualized service planning and care coordination for children with intensive service needs under contract with the state. Currently, contracts are non risk-based. CMOs use child and family teams to develop individualized plans, which are required to be strengths-based and culturally relevant. They also must address safety and permanency issues for those children referred to CMOs who are involved with the child welfare and juvenile justice systems. The CMOs employ care managers, who carry small caseloads (1:10) and who receive close supervision and support from clinical supervisors. Care managers and child and family teams are supported by family support coordinators and community resource development specialists, whose job it is to identify and develop informal community supports and natural helpers to augment treatment services. The Care Management Organizations work closely with Family Support Organizations (i.e., family-run organizations) to link families to natural supports and a peer network.

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State-Specific Example…

VT Vermont

Using Local Lead Agencies and Interagency Teams

Vermont's system of care for children with behavioral health problems has state and local structures that serve as focal points at each level and across systems for policy and management. The Department of Mental Health is the lead state office for children's mental health. The Department's Child, Adolescent and Family Unit contracts with ten local Designated Agencies (nonprofit, designated by the Commissioner) that serve the state's 14 counties to provide community mental health services for a specific geographic region. The Designated Agency is the locus of accountability for services, cost, and care management for children with intensive mental health needs. The local agency that has lead responsibility for ensuring that the coordinated service plan (developed by an individual interagency treatment team) is in place can vary depending on the needs of the child and family. If the child is in the custody of the Department for Children and Families (child welfare agency), then that agency takes the lead. If the issues are primarily exhibited in the child's educational environment and the child is not in state custody, then the local school district is responsible. In all other cases, the designated community mental health agency is responsible for developing and making sure that the coordinated services plan that outlines goals and needed services and supports is carried out. Decisions about services, care and cost are made at the local level, driven by the needs of the child and family and provided within the limits of legislative mandates and existing resources. If problems or issues arise that the individual treatment team cannot resolve, the team or any member may initiate a referral to the Local Interagency Team in the region for help. The State Interagency Team is a mandated state-level unit for further consideration of issues that are not resolved locally and for additional assistance with implementation of the coordinated service plan.

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State-Specific Example…

NE Central Nebraska

Using Integrated Care Coordination Units Supported by Regional Behavioral Health and Child Welfare Authorities

Region 3 based its system of care on an existing infrastructure (Region 3 Behavioral Health Services [BHS]). When it received a federal system of care grant in 1997, there was no need to create and support a new structure to implement the system of care. Region 3 BHS already had a statutory responsibility to administer behavioral health services. Using the existing infrastructure rather than creating a new, separate entity with grant funds greatly enhanced the chances for sustainability. The cooperative agreement between the ***Nebraska*** Department of Health and Human Services (DHHS) and Region 3 BHS to establish an individualized system of care for youth with intensive needs who are in state custody included a joint responsibility for utilization management to monitor utilization of higher levels of care and assist care coordinators in accessing alternative placement and treatment services. The Care Management Team (CMT) serves this function. It was developed to ensure that children/youth are cared for in the least restrictive, highest quality, and most appropriate level of care. It serves children at risk of out-of-home placement, as well as children in out-of-home placement. To determine the most appropriate level of care, the CMT administers an initial assessment using the Child and Adolescent Functional Assessment Scale (CAFAS), interviews caregivers, reviews youth

Continued on next slide…

Nebraska Example Continued…

records (including mental health assessments and risk assessment) and participates in the child and family team meetings when necessary. The CMT tracks referrals from DHHS and other service providers, determines needed services and supports, and identifies service gaps. The CMT determines which children/families in Central Nebraska meet the criteria for the Intensive Care Coordination Unit (ICCU), which ICCU has the capacity to accept them, and which children should be prioritized to receive care first. If there is no opening in an ICCU, the CMT will facilitate a child and family team meeting. The CMT conducts ongoing utilization review of children in ICCU. The CMT is staffed by licensed mental health clinicians. This is very helpful in the negotiations with Magellan, the statewide Administrative Services Organization, for access to Medicaid services for individual children. Region 3 BHS and the Central Area Office of Protection and Safety fund the CMT. In FY 2005, 210 youth were referred to the CMT.

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State/County Organizational Models

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Examples of State/County Roles

- Several states have no county role in either management or funding of MH-ID/DD services (New England)
- Some states have county-based service providers using both Medicaid and non-Medicaid funds including local levies (Virginia, Georgia)
- Some states have county-based integrated managed care just for behavioral health (Medicaid plus state funds – Arizona, Washington, Oregon, Colorado)
- Some states have statewide managed care for Medicaid behavioral health (Massachusetts, Iowa)

Examples of State/County Roles

- In some states, Counties pay match for Medicaid but don't have full control over Medicaid service access and utilization (Ohio, New York)
- Some states have separate county-based BH and ID-DD systems with Medicaid BH under managed care and state/local general funds not under managed care (Pennsylvania)
- Some states have integrated county-based managed care models (BH + ID-DD, Medicaid + state funds – Michigan, North Carolina)

Examples of State/County Roles

- Iowa is unique in moving towards a county-based regional system to manage non-Medicaid services while Medicaid BH services are managed through a statewide managed care company. North Carolina had that model, but is now moving to integrate Medicaid and non Medicaid for both BH and ID-DD services